45th day 70th
3-10-19 4-4-19

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/25/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
POC #1	445519	A. BUILDING _____ B. WING _____	01/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NHC PLACE SUMNER	140 THORNE BOULEVARD GALLATIN, TN 37066

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F 000	INITIAL COMMENTS A recertification survey was completed on 1/24/19 at NHC Place Sumner. Deficiencies were cited under 42 CFR PART 483, Requirements for Long Term Care Facilities.	F 000		
F 638 SS=D	Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment. A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to complete a Quarterly Minimum Data Set (MDS) for 1 (#10) of 32 residents reviewed. The findings include: Medical record review revealed Resident #10 was admitted to the facility on 2/23/18 with diagnoses included Benign Neoplasm of Meninges, Nontraumatic Intracranial Hemorrhage, and Toxic Encephalopathy. Medical record review revealed Resident #10 had a Quarterly MDS dated 8/24/18 and a Significant Change MDS dated 9/27/18. Further medical record review revealed no Quarterly MDS was completed in December 2018. Interview with Registered Nurse (RN) #1 on 1/23/19 at 4:20 PM in her office revealed Resident #10 did not have a Quarterly MDS completed in December 2018. RN #1 stated,	F 638	1. Center completed quarterly assessment for resident #10 with ARD of 1/22/2019 to ensure resident had all assessments required by RAI guidelines. 2. A 100% audit was completed on 2/5/2019 for all inhouse residents as of 1/22/2019 with no other residents found to have missing assessments based on quarterly review instrument specified by the state and approved by CMS. 3. All MDS nurses were educated by the DON on 2/5/2019 that a quarterly assessment must have an ARD of previous assessment of any type plus no more than 92 days, must be completed within 14 days of ARD, and transmitted no later than 14 days from completion date. 4. Monitoring includes residents with a length of stay 90 days or greater to ensure timeliness of quarterly assessment per RAI guidelines and will include: weekly monitoring of all assessments for 4 weeks, then biweekly monitoring for 2 weeks, then randomly. The results will be reported through the QA process monthly by the DON for 2 months and then at the discretion of the committee.	2/8/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE Administrator | (X6) DATE 2/7/19

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 638	Continued From page 1 "The Quarterly MDS was due in December 2018 and I feel like I just missed it." F 641 Accuracy of Assessments SS=D CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of facility investigation, and interview, the facility failed to accurately assess 2 (#21 and #68) of 32 residents reviewed. The findings include: Medical record review revealed Resident #21 was admitted to the facility on 12/13/17 with diagnoses included Urinary Tract Infection, Shortness of Breath, and Falling. The resident had been discharged to the hospital on 12/29/18 and readmitted to the facility on 1/4/19. Medical record review of the Quarterly Minimum Data Set (MDS) dated 11/15/18 revealed Resident #21 had no falls. Review of the facility investigation dated 12/20/18 revealed Resident #21's legs gave out and the staff present assisted the resident to the floor. Further review revealed the resident had no injury resulting from the fall. Medical record review of the Discharge MDS dated 12/29/18 revealed Resident #21 had no fall since admission/entry or reentry or prior assessment.	F 638 F 641	1. For resident #21 the inaccurate coding of MDS pertaining to falls and discharge destination were corrected. MDS assessment with ARD of 12/29/2018 was corrected on 1/24/2019 and MDS with ARD 1/11/2019 was corrected on 1/29/2019. For resident #68 the discharge MDS with ARD 12/11/2018 and inaccurate coding of discharge destination was corrected on 1/29/2019. 2. 100% audit of all MDS assessments in regards to accurate coding of falls and discharge destination, will a look back of 90 days prior to 1/22/2019, was conducted. The Audit revealed out of the 49 residents identified with falls, 9 residents were identified with errors in coding of falls and 7 out of 227 assessments with errors in coding of the discharge destination. All corrections will be made by 2/7/19 .	2/8/19

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F 641	Continued From page 2 Medical record review of the Admission 5 day MDS dated 1/11/19 revealed Resident #21 had 1 fall with injury since admission/entry or reentry or prior assessment. Interview with Registered Nurse (RN) #1, responsible for the MDS, on 1/24/19 at 9:35 AM in the conference room, after reviewing the facility investigations, when asked if the 12/29/18 MDS failed to accurately assess Resident #21's fall on 12/20/18, the RN stated "Yes." When the RN was asked if the 1/11/19 MDS was to identify the 12/20/18 fall the RN stated "...No, the 12/20/18 fall would be on the 12/29/18 MDS..." Further interview with the RN at 11:35 AM in the conference room confirmed the 12/29/18 and the 1/11/19 MDS's "...were not correctly coded for falls..." Medical record review revealed Resident #68 was admitted to the facility on 11/10/18 and discharged to the community with home health services on 12/11/18. Medical record review of the physician order dated 12/4/18 revealed "...DC [discharge] home on 12/11/18 with home health, PT [Physical Therapy] , OT [Occupational Therapy] and nursing..." Medical record review of the Discharge and Transfer Discharge Plan of Care and Recapitulation revealed Resident #68 was discharged to the community with home health on 12/11/18. Medical record review of the Discharge MDS dated 12/11/18 revealed Resident #68 was	F 641	3. All MDS nurses were educated by the DON on the accurate coding of falls and discharge destinations per the RAI guidelines on 2/5/2019. 4. Ongoing monitoring will include monitoring of all MDS assessments for accuracy of coding of falls and discharge monitoring. Monitoring will be completed by the DON or her designee weekly for 4 weeks, biweekly for 2 weeks, then randomly. The results will be reported through the QA process monthly by the DON for 2 months and then at the discretion of the committee.	2/8/19

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F 641	Continued From page 3 discharged to an acute hospital. Interview with the Director of Nursing on 1/24/19 at 5:55 PM in the conference room confirmed the 12/11/18 discharge MDS was not accurate for the discharge status to an acute hospital. Interview with RN #1, responsible for the MDS, on 1/24/19 at 6:10 PM in the conference room confirmed the discharge MDS dated 12/11/18 failed to accurately identify the discharge status as a community discharge.	F 641		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline	F 655	1. For resident #50 admitted on 12/6/2018, baseline care plan was put in place on 12/9/2018. 2. 100% audit was conducted for all residents inhouse on 1/22/2019 to ensure baseline care plans were in place. The audit revealed that 10 residents out of 87 did not have baseline care plans initiated timely. Since 1/22/2019 to 2/5/2019, all baseline care plans have been completed within 48 hours. 3. Admission nurse, unit managers, and charge nurses will be educated per the DON on all residents having a baseline care plan in place within 48 hours of admit. Education will be completed by 2/8/2019.	

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F 655	Continued From page 4 care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on facility policy review, medical record review and interview, the facility failed to have a baseline care plan adressing falls for 1 (#50) of 32 residents reviewed. The findings include: Review of the facility policy, Care Plan Development dated 7/3/08 revealed "...Interim plan of care within 48 hours of admission addressing the immediate needs of the patient..." Medical record review revealed Resident #50 was admitted to the facility on 12/6/18 with diagnoses included Specified Disorders of the Brain, Generalized Osteoarthritis, Muscle Weakness and History of Falling.	F 655	4. Ongoing monitoring will include review of all new admissions per the admission nurse or unit manager within 48 hours of admit ensuring baseline care plans are completed timely. Weekly monitoring of all baseline care plans will take place for 4 weeks, then biweekly for 2 weeks, then randomly per the DON or her designee. The results will be reported through the QA process monthly by the DON for 2 months and then at the discretion of the committee.	2/8/19

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F 655	Continued From page 5 Medical record review of the care plan dated 12/6/18 revealed the baseline care plan was updated on 12/9/18 for falls risks. Interview with the Director of Nursing (DON) on 1/24/19 at 5:51 PM in the conference room confirmed "...the baseline care plan is part of the admission process and should be completed in 48 hours..." Further interview with the DON confirmed "...looks like on the day she was entering the care plans he had a fall..."	F 655		

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E 000	Initial Comments An emergency preparedness survey was completed 1/22/19 to 1/24/19 at NHC Place Sumner. No deficiencies were cited under FED-E-1.00.	E 000		

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